(9)

No. 97-1489

In The

Supreme Court of the United States

October Term, 1997

YOUR HOME VISITING NURSE SERVICES, INC.,

Petitioner,

v.

SECRETARY OF HHS,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Sixth Circuit

PETITIONER'S BRIEF ON THE MERITS

DIANA L. GUSTIN
Counsel of Record
11 Town Square
Post Office Box 1349
Norris, Tennessee 37828
(423) 494-3000
Counsel for Petitioner

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

61 pp

QUESTIONS PRESENTED FOR REVIEW

I. Is regulation 42 C.F.R. § 405.1885(c) based on a permissible construction of the Medicare statute?

II. Is there jurisdiction for review of a refusal to reopen a Medicare provider's cost report under:

- Provider Reimbursement Review Board statute, 42 U.S.C. § 1395oo?
- Federal Question Jurisdiction, 28 U.S.C. § 1331?
- Mandamus Jurisdiction, 28 U.S.C. § 1361?
- Administrative Procedure Act, 5 U.S.C. § 706?

PARTIES TO THE PROCEEDINGS

The petitioner, plaintiff-appellant in the proceedings below, is Your Home Visiting Nurse Services, Inc. and its home health care agency providers licensed as numbers 44-7100, 44-7300, 44-7234, and 44-7304 (Tennessee corporations). There is no parent or non-wholly owned subsidiary company to be listed as required by United States Supreme Court Rule 29.6.

Respondent is the Secretary of Health and Human Services, represented by the Solicitor General as Counsel of Record for the Department of Health and Human Services.

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The opinion of the court of appeals is reported at *Your Home Visiting Nurse Services, Inc. v. Secretary of Health and Human Services*, 132 F.3d 1135 (6th Cir. 1997). The opinion of the district court is unreported. *See* Pet. App. 17-33. The decision of the Provider Reimbursement Review Board is also unreported. *See* Pet. App. 34-35.

JURISDICTION

The court of appeals for the Sixth Circuit entered its judgment on December 22, 1997. *See* Pet. App. 38-39. The petition for a writ of certiorari was riled on March 11, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1). The petition for a writ of certiorari was granted on June 15, 1998 as to the first two questions presented for review within the writ.

STATUTORY PROVISIONS AND OTHER AUTHORITIES INVOLVED

The statutory provisions and other authorities involved include 5 U.S.C. § 706; 28 U.S.C. § 1254(1); 28 U.S.C. § 1331; 28 U.S.C. § 1361; 42 U.S.C. § 405(h); 42 U.S.C. § 1395x(v)(1)(A)(ii); 42 U.S.C. § 1395oo; 42 C.F.R. § 405.1885 *et seq.*; 42 C.F.R. § 421.5(b); and 42 C.F.R. § 413.102(b)(2)(i).

STATEMENT OF THE CASE

The petitioner provides home health care services to Medicare beneficiaries and is entitled to receive reasonable reimbursement from the Medicare program for these services under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* Part A of the Medicare statute covers basic institutional health costs, including covered home health care. 42 U.S.C. § 1395x(m). The respondent is ultimately responsible for administration of the Medicare Program through the Health Care Financing Administration (HCFA) which contracts with insurance companies such as Blue Cross & Blue Shield of Tennessee and Blue Cross & Blue Shield of South Carolina to perform reimbursement and review functions in the role of fiscal intermediary. *See* 42 C.F.R. § 421.5(b).

Providers, such as petitioner, submit cost reports to their intermediary at the close of each fiscal year. 42 U.S.C. § 1395g; 42 C.F.R. § 405.1801(b); 42 C.F.R. § 413.24(f). The intermediary then determines allowable cost and issues a Notice of Program Reimbursement letter. 42 C.F.R. § 405.1803. This determination may be reopened under certain circumstances. 42 C.F.R. § 405.1885.

Petitioner discovered new and material evidence concerning its December 31, 1989 cost reports that prompted its request for reopening of the cost reports. The request was made within three years from the date of the Notice of Program Reimbursement letters. The intermediary refused to reopen the cost reports. Pet. App. 36-37. Thereafter, the Provider Reimbursement Review Board (the Board) refused to accept jurisdiction of petitioner's request for review of the refusal to reopen the cost reports. Pet. App. 34-35. Petitioner appealed the Board's decision to the district court where the case was dismissed and the Board's decision was upheld. Pet. App. 16-33. The district court also refused to accept jurisdiction to hear petitioner's case on any of the alternative theories offered. *Id.* The Sixth Circuit Court of Appeals affirmed the district court decision. Pet. App. 1-15.

SUMMARY OF ARGUMENT

The Secretary interprets regulation 42 C.F.R. § 405.1885(c) in such a way that defines exclusive jurisdiction for reopening a report to mean that there is no review of a refusal to reopen a final determination. The petitioner asserts this is not a reasonable interpretation of the Medicare statute and therefore is not a permissible construction of 42 U.S.C. § 1395oo(a). Other sections of the Medicare statute also support the position that review for a refusal to reopen must be allowed. Any other reading of the statute would render provisions regarding retroactive corrective adjustments meaningless and therefore superfluous which would not be in accordance with the statutory scheme taken as a whole. 42 U.S.C. § 1395x(v)(1)(A)(ii).

If there is no review of a refusal by an intermediary to reopen a final determination, then complete power rests with one party. Not only does this conflict with the statutory mandate that regulations *shall* provide for the making of suitable retroactive corrective adjustments, but

it also creates a de facto double standard. This contradiction cannot be construed as a reasonable reading of the Medicare statute.

The Medicare statute, 42 U.S.C. § 1395oo, allows providers to seek review of final determinations. This review process must include those final determinations that are refusals to reopen. The Secretary should not be permitted to extinguish the right to the review procedure set forth in the Medicare statute. If the Court agrees with this contention as the correct reading of the law, then an avenue of administrative review would be available which might dispense with the need to resort to federal question jurisdiction in order to obtain judicial review of a refusal to reopen a final determination. If the Court is not convinced that 42 U.S.C. § 1395oo provides an avenue for administrative appeal of refusals to reopen, then reliance upon 28 U.S.C. § 1331 must again be proposed as a jurisdictional grant for this situation.

It would be implausible to think that Congress intended there be no forum to adjudicate statutory and constitutional challenges to regulations promulgated by the Secretary. In *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), this Court severely restricted the decision of *Heckler v. Ringer*, 466 U.S. 602 (1984) when it upheld jurisdiction under 28 U.S.C. § 1331 to challenge the validity of a regulation authorizing payment. Therefore, to the extent that claims involve matters outside the articulated statutory review process, jurisdiction should be available under § 1331. *Medical Fund-Philadelphia Geriatric Center v. Heckler*, 804 F.2d 33, 38-39 (3rd Cir. 1986).

If this Court finds federal question jurisdiction is precluded by 42 U.S.C. § 405(h) of the Medicare statute, then the petitioner would rely upon 28 U.S.C. § 1361 as an alternative for jurisdiction, or in addition to 28 U.S.C. § 1331. This Court has not yet ruled upon the question of whether the third sentence of 42 U.S.C. § 405(h) is a bar to mandamus jurisdiction in Social Security cases. Many Courts of Appeal that have considered the question have ruled that mandamus remains available under the Social Security Act. There are two requirements that must be met regarding mandamus jurisdiction. 28 U.S.C. § 1361. The first pertains to exhaustion of all other avenues of relief and second concerns the breach of a nondiscretionary duty. *Id.* Petitioner asserts it met both requirements and therefore mandamus is a valid basis for jurisdiction in this matter.

Under the Administrative Procedure Act (APA) the Secretary's decisions regarding provider's claims for Medicare reimbursement shall be set aside where a decision is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence, or contrary to law. 5 U.S.C. § 706(2)(A). If this Court does not establish a provider's right to obtain review of a refusal to reopen, intermediaries may abuse their discretion and remain unchallenged. The Secretary's reading of 42 C.F.R. § 405.1885(c) precludes review of every decision which refuses to reopen a cost report and therefore insulates from review even the most abhorrent abuses of discretion. There must be a forum with the authority both to review such a decision and to set it aside if the decision is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence, or contrary to law.

ARGUMENT

I. Is 42 C.F.R. § 405.1885(c) based on a permissible construction of the Medicare Act?

The regulation at issue in this case is 42 C.F.R. § 405.1885(c) which states that "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." The Secretary interprets her regulation in such a way that defines exclusive jurisdiction for reopening to mean that there is no review of the decision concerning the reopening request. The petitioner asserts this is not a reasonable interpretation of the Medicare statute and therefore is not a permissible construction of 42 U.S.C. § 1395oo(a). This section of the statute allows a provider to seek review of a final determination if:

- the provider is dissatisfied with ***a final determination*** of the organization serving as its fiscal intermediary as to the amount of total program reimbursement due the provider;
- the amount in controversy is $10,000 or more; and,
- the provider files a request for a hearing before the Provider Reimbursement Review Board within 180 days after notice of the intermediary's final determination.

42 U.S.C. § 1395oo(a) (emphasis added).

The judiciary is the final authority on issues of statutory construction. Administrative constructions which are found to be contrary to clear congressional intent must be rejected. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 n.9 (1984). An agency's construction of a statute is only entitled to deference if it

is reasonable and not in conflict with the intent of Congress. *United States v. Riverside Bayview Homes, Inc.*, 474 U.S. 121, 131 (1985).

The respondent references Section 1395oo(a)(1)(A)(i) of the statute in its brief and correctly notes that this section authorizes the Board to review a fiscal intermediary's *"final determination* . . . as to the amount of total program reimbursement due to the provider . . . for the period covered by the provider's cost report." Resp't br. to Pet. Cert. 8 (emphasis added). The Respondent then offers a conclusion which petitioner believes is unwarranted:

> "That language *plainly refers* to the fiscal intermediary's issuance of the NPR reflecting the total reimbursement due the provider for that fiscal year. It does not readily encompass, however, a denial by the intermediary of a request to alter a prior determination as to whether particular cost items are reimbursable."

Resp't br. to Pet. Cert. 8 (emphasis added).

Petitioner disagrees. That language does not plainly refer to the fiscal intermediary's Notice of Program Reimbursement, it simply refers to ***a*** final determination. An agency's interpretation of a regulation is valid only if that interpretation complies with the actual language of the regulation. *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945). The plain language of the Secretary's own regulation does not bar review because 42 C.F.R. § 405.1885(c) reads: "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or

decision." The language says nothing about reviewability; it merely vests the discretion to decide whether or not to reopen. *State of Oregon v. Bowen*, 854 F.2d 346, 349 (9th Cir. 1988). Here, the Secretary's interpretation does not comply with the actual language used in the regulation nor does it comply with the language used in the statute that permits review of a final determination.

The Secretary must agree that the refusal to reopen is a final determination. In fact, in *State of Oregon*, 854 F.2d at 346, the court noted such an admission: "[a]lthough the NPR is often the final determination in question, the fiscal intermediary's refusal to reopen also qualifies as a final determination, a fact the Secretary concedes in his briefs." Since the Secretary has recognized the refusal to reopen is a final determination, this *type* of final determination can only be classified as an exception to the statute which permits providers the opportunity to request review of final determinations *if* the Secretary interprets the language in the statute to mean something other than what it states on its face. In order to block review of this type of final determination, the Secretary interprets the phrase "a final determination" to mean a Notice of Program Reimbursement. This interpretation is unnecessary and uncalled for because the phrase "a final determination" is not ambiguous. The Secretary's interpretation unfairly limits the right to request a review.

Petitioner asserts that the Secretary of Health and Human Services' interpretation of the regulation at issue is contrary to the clear congressional intent. Congress enacted provisions that assure an appeal process will be available for review of final determinations regarding

Medicare reimbursement. The plain language of the statute simply states that a provider that is "dissatisfied with a final determination" may seek review. 42 U.S.C. § 1395oo(a)(1)(A)(i). The Secretary's interpretation of the phrase "a final determination" to mean the Notice of Program Reimbursement is an obvious departure from the plain language used in the statute. The word "interpret" means to explain or tell the meaning of, to translate, elucidate; to construe in light of individual belief, judgment or *interest*. Webster's Collegiate Dictionary (5th ed.) (emphasis added). It is in the Secretary's interest to interpret the phrase "a final determination" in a very limited way in order to cut off the right to review. This is not in keeping with the statutory provision that allows review of a final determination when a provider is dissatisfied. For this reason, the Secretary's interpretation should not be allowed to stand.

In *Chevron*, two questions are raised which must be answered when an agency's construction of a statute it administers is called into question. The first question is whether Congress itself has addressed the matter:

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency must give effect to the unambiguously expressed intent of Congress.

Chevron, 467 U.S. 837, 842-843.

According to the dictates of *Chevron*, if the intent of Congress is clear, that is the end of the matter. Here we have simple language that the Secretary construes as unclear in order to validate an interpretation that is inconsistent with congressional intent. Therefore, the Secretary's construction of the Medicare statute (through her reading of regulation 42 C.F.R. § 405.1885(c) to prohibit review of a final determination) is not entitled to deference. It fails the first test of *Chevron* because there is no need for an interpretation of the unambiguous language.

If however, this Court concludes that interpretation of the language at issue was appropriate, then the analysis under *Chevron* shifts to consider whether the agency's construction of its statute is reasonable. The review for reasonableness must examine whether the agency properly exercised its discretion within the sphere of its delegated authority. *Chevron*, 467 U.S. 837. Petitioner asserts the Secretary's interpretation is not entitled to deference because it also fails the second test set out in *Chevron*:

> If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Id. at 842-843.

Petitioner asserts the Secretary's reading of the statute is not a permissible construction of the statute because it is in conflict with the intent of Congress and with the plain meaning of 42 U.S.C. § 1395oo(a)(1)(A)(i), which allows review of a final determination. Petitioner also contends that the Secretary's interpretation of the statute (which would allow her to cut off all judicial review of refusals to reopen) is inconsistent with the presumption of judicial review, as stated previously in the Petition for Certiorari. Pet. Cert., 9-22 (adopted and incorporated herein by reference).

As noted above, the first step in the *Chevron* analysis is to determine whether Congress has expressed an intent on the question at issue. *Chevron*, 467 U.S. at 842-843. The second step is to determine whether or not the agency's construction of the statute is reasonable. *Id.* Both steps require an understanding of the statute and the congressional intent regarding the question at issue. Congressional intent can appear within specific language in the statute, or it could be apparent in light of the statutory scheme taken as a whole.

Petitioner asserts that other parts of the Medicare statute also support its position that review for a refusal to reopen must be allowed. Any other reading of the statute would render provisions regarding retroactive corrective adjustments meaningless and therefore superfluous which would not be in accordance with the statutory scheme taken as a whole. In support of this argument, petitioner would show the Secretary's interpretation of her regulation is in conflict with another section of the Medicare statute. This was addressed by the court in *State of Oregon*, 854 F.2d 346 where the

question of clear congressional intent regarding the availability of review when there is a refusal to reopen was discussed at length. In that case, the court held the Secretary's claim of unreviewability cannot be supported by the plain language of the Medicare statute, specifically citing the section which, in effect, calls for the reopening process:

> the Secretary's claim of unreviewability cannot be supported by the plain language of the section of the Medicare Act authorizing reopening procedures. The statutory authorization of reopening mandates that the regulation should "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. § 1395x(v)(1)(A)(ii) (1982). Nothing in the plain language of this mandate indicates unreviewability.

Id. at 349.

Petitioner adopts the position of the court in *State of Oregon* regarding the frustration of congressional intent. In that decision, the Ninth Circuit Court of Appeals correctly observed that the Secretary's regulation frustrated two clear congressional purposes.

> First, via section 1395oo(a) Congress intended to give providers a specific means by which to appeal a fiscal intermediary's cost determination . . . thus, the Secretary's regulation, at least as the Secretary now wishes to interpret it, partly eviscerates the congressional intent of providing administrative review of a fiscal intermediary's cost determination because his policy

> would allow questions of mistaken cost determination to go unreviewed. Second, because the Secretary would shelter the reopening decision from review, congress' decision to provide a fair method to make retroactive adjustments is impermissibly negated.

Id. at 350. *See also* 42 U.S.C. § 1395x(v)(1)(A)(ii).

The Secretary's position of unreviewability is not reasonable when read in conjunction with the portion of the statute which requires retroactive corrective adjustments to assure reasonable cost for Medicare services are paid. United States Code Title 42 Section 1395x(v)(1)(A)(ii) requires the Secretary to develop regulations to allow retroactive corrective adjustments for payment of the reasonable cost of services:

> Such regulations shall . . . provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by methods of determining costs proves to be either inadequate or excessive.

42 U.S.C. § 1395x(v)(1)(A)(ii).

Such regulations do not provide for the making of suitable retroactive corrective adjustments where the Secretary's agents are allowed to refuse to make the corrective adjustments and the Secretary prohibits review of the refusal. If the Secretary's position is accepted as reasonable, then the statutory mandate for the Secretary to develop regulations which *shall* provide for *suitable retroactive corrective adjustments* is useless to providers who seek a corrective adjustment because their reimbursement was inadequate. This makes a provider's resort to 42 C.F.R. § 1885(c), the regulation that allows a request for

reopening futile when, as in this case, a provider's request is denied and there is no review of the denial available. *The right to request justice is meaningless without the power to enforce fair consideration of the request for relief.* If there is no review of a refusal by an intermediary to reopen a final determination, then complete power rests with one party. Not only does this conflict with the statutory mandate that regulations *shall* provide for the making of suitable retroactive corrective adjustments, but it also creates a de facto double standard because the Secretary is more than willing to reopen a cost report to recoup excessive amounts of reimbursement paid to a provider, but is often quite reluctant to reopen a cost report when a provider was underpaid. In this very case, for the cost reporting period at issue, the intermediary reopened the cost report for petitioner's provider 44-7234 (Sneedville, Tennessee office) to recover excessive compensation which was inadvertently paid to a nurse whose license had been revoked by the State of Tennessee. *See* Docket entry no. 7 from the U.S. District Court record, pp. 14-15 and Exhibit B thereto. The intermediary nevertheless steadfastly refused to reopen the very same cost report for the same year, December 31, 1989, to allow additional compensation to the petitioner's owners even though a salary survey created by an intermediary recognized the claimed salary was reasonable. This de facto double standard is in direct conflict with the statutory proclamation that corrective adjustments be made for a provider when the cost paid proves to be ***either*** inadequate or excessive. 42 U.S.C. § 1395x(v)(1)(A)(ii).

More evidence of the de facto double standard exists in the case law on this subject. Many cases exist where

the Secretary seeks reopening to *recover* reimbursement yet refuses to reopen to allow a provider additional reimbursement. Most convincing, perhaps, is the Secretary's position as noted in the recent decision by this Court on the subject of Medicare reimbursement of Graduate Medical Education costs. The Secretary's concern for the accuracy of payment required reopening of base year cost reports (even beyond the three year time period normally allowed) in order to assure accurate payment. *Regions Hospital v. Shalala*, 118 S.Ct. 909 (1998).

On February 24, 1998, this Court rendered a decision regarding the Secretary's interpretation of the Graduate Medical Education (GME) amendment and her regulation permitting a reaudit of the base year even where the 1984 cost reports were beyond the three year time period. *Id.* In that case, the Court examined the reaudit regulation that permitted the Secretary to reopen a determination by an intermediary, the Board, or the Secretary herself to recoup excessive reimbursement for a given year. *Id.* The GME amendment required the Secretary to determine a hospital's cost for the reporting period that began in 1984. *Id.* The Secretary interpreted this statute as allowing a reaudit of the 1984 cost reporting periods. *Id.* The reaudit rule was considered a reasonable interpretation of the GME amendment primarily based upon the statute's instruction to determine for the 1984 year the "amount recognized as reasonable." *Id.* at 899. This Court emphasized that the reaudit rule brings the base-year calculation in line with "Congress' pervasive instruction for reasonable cost reimbursement". *Id.* at 900. The rule was recognized as a means to "enable the Secretary . . . to carry out her responsibility to reimburse only reasonable

costs, and to prevent payment of uncovered, improperly classified, or excessive costs." *Id.*

It is the responsibility of the Secretary to pay the reasonable cost, i.e., the correct amount of Medicare reimbursement. It is therefore inconsistent for the Secretary to seek reopenings only when Medicare reimbursement is being recouped and to acquiesce in her intermediary's refusal to reopen cost reports when additional Medicare reimbursement is being sought.

In the present case, the respondent took the position that reviewability of denials of requests to reopen presents an important and recurring issue in the administration of the already overburdened Medicare program. Resp't br. to Pet. Cert. 15. Petitioner would point out that a review process will always create some additional administrative work. Nevertheless, the importance of carrying out congressional intent that reasonable cost be paid under the GME amendment created administrative burdens on the Medicare Program by virtue of the reaudit regulation itself. It is disingenuous of the Secretary to have argued that her interpretation of the GME reaudit regulation is reasonable when it adds administrative burden to the program and now voice concern for the administrative burden which review of the refusal to reopen might cause. If the Secretary is recouping Medicare reimbursement she is willing to burden the administrative process, but when a provider requests additional Medicare reimbursement she streamlines the process with her prohibition on administrative review.

It is readily apparent that the Secretary's decisions to reopen cost reports to recoup Medicare reimbursement

will automatically allow a provider the right to an administrative review process because an Amended Notice of Program Reimbursement will be issued once a cost report is reopened to recover Medicare funds. On the other hand, the intermediary's decisions to refuse reopening will not receive the administrative review process under the Secretary's reading of her regulation 42 C.F.R. § 405.1885(c). Providers' reopening requests (which are obviously made for the purpose of obtaining additional reimbursement) do not receive the same level of administrative review. This leaves the reopening process inconsistent between the parties. The Secretary has the power to make a reopening when she seeks to recoup Medicare reimbursement and the power to refuse a reopening request by a provider if additional reimbursement is sought. This inconsistency is evidence of the double standard that exists. This contradiction cannot be construed as a reasonable reading of the Medicare statute.

II. Is there jurisdiction for review of a refusal to reopen a Medicare provider's cost report under the Provider Reimbursement Review Board Statute, 42 U.S.C. § 1395oo?

Petitioner asserts, for all of the reasons stated in the preceding section of this brief, that there is no need for interpretation of the statutory section at issue because the phrase "a final determination" is not ambiguous. In the alternative, even if this Court finds it appropriate to interpret the Medicare statute on this point, the Secretary's interpretation of her regulation is in direct conflict with the language contained in the Medicare statute. Therefore, the Secretary's construction is not entitled to

deference. Instead, the plain meaning of the statute, which allows the provider that is dissatisfied with a final determination to request review of that final determination, should be accepted as controlling authority on this question. United State Code Title 42, Section 1395oo allows providers to seek review of final determinations. This review process must include those final determinations that are refusals to reopen. The Secretary should not be permitted to extinguish the right to the review procedure set forth in the Medicare statute, "for the court, as well as the agency must give effect to the unambiguously expressed intent of Congress." *Chevron*, 467 U.S. at 842-843.

III. Is there jurisdiction for review of a refusal to reopen a Medicare provider's cost report under the Federal Question Statute, 42 U.S.C. § 1331?

Petitioner asserts that the Medicare statute, 42 U.S.C. § 1395oo, does provide an appeal process as stated in the preceding sections of this brief. If the Court agrees with this contention as the correct reading of the law, then an avenue of administrative review would be available which might dispense with the need to resort to federal question jurisdiction in order to obtain judicial review a refusal to reopen a final determination. However, even if the petitioner is successful at this juncture and prevails based upon its reading of 42 U.S.C. § 1395oo, the question still remains as to the Sixth Circuit decision that petitioner's claims were not entitled to review at the U.S. District Court level under federal question jurisdiction because the Medicare statute precludes federal question jurisdiction as a basis for review. Pet. App. 12. *See also*

Your Home Visiting Nurse Services, Inc. v. Secretary of Health and Human Services, 132 F.3d 1135, n.3 (6th Cir. 1997) (where the court questioned the continuing validity of the amount/methodology distinction referenced in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986)). Petitioner adopts and incorporates by reference its argument presented in the Petition for Certiorari, pages 9-22, regarding the presumption to judicial review under the federal question statute. If petitioner does not convince the Court that 42 U.S.C. § 1395oo provides an avenue for administrative appeal of refusals to reopen, then reliance upon 28 U.S.C. § 1331 must again be proposed as a jurisdictional grant for this situation.

In *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 678 (1986), this Court concluded it would be implausible to think that Congress intended there be no forum to adjudicate statutory and constitutional challenges to regulations promulgated by the Secretary. Unfortunately, the Sixth Circuit would not accept petitioner's argument that collateral challenges, not requiring consideration of the merits of a Medicare claim, are outside the scope of the statute. *Your Home Visiting Nurse Services v. Shalala*, 132 F.3d 1135 (6th Cir. 1997); Pet. Cert. 11.

> Your Home's argument is foreclosed by *Heckler v. Ringer*, 466 U.S. 602 (1984). In *Ringer*, the Secretary of Health and Human Services issued an administrative ruling that Medicare did not cover certain surgical procedure. Four individual claimants brought a suit challenging the ruling, asserting federal question jurisdiction. The Court held that § 405(h) barred the suit, finding that "the inquiry in determining whether

> § 405(h) bars federal question jurisdiction must be whether the claim 'arises under' the Act, not whether it lends itself to a 'substantive' rather than a 'procedural' label." Id. at 614-15. The proper test is whether " 'both the standing and the substantive basis for the presentation' of the claims" is the Medicare statute. Id. at 615 (*quoting Weinberger v. Salfi*, 422 U.S. 749, 760-61 (1975)).

Your Home Visiting Nurse Services, 132 F.3d 1135; Pet. Cert. App. 11-12.

The Sixth Circuit's reliance upon *Heckler v. Ringer*, 466 U.S. 602 (1984) to the exclusion of the more recent decision *Michigan Academy*, 476 U.S. 667, sets the stage for the denial of jurisdiction in U.S. District Courts when providers challenge the Secretary's regulations or procedures which contradict the Medicare statute or constitutional provisions. Petitioner presented two collateral challenges in the proceedings below: the validity of regulation 42 C.F.R. § 1885(c); and the intermediary's failure to abide by 42 C.F.R. § 413.102(b)(2)(i) which requires that owners' compensation be such an amount as would ordinarily be paid by comparable institutions. While it could be argued that the lower courts agreement with the Provider Reimbursement Review Board's refusal to grant jurisdiction to hear this matter essentially addressed the first collateral challenge, neither court addressed the allegation concerning the intermediary's violation of a federal regulation. Petitioner specifically raised this issue. *See* Docket entry no. 7, U.S. District Court record, plaintiff's brief, 11-12:

> The intermediary's refusal to review evidence was *arbitrary and capricious* in that BCBS/SC refused to review the evidence concerning the previous intermediary's failure to follow the Medicare guidelines which require owners compensation to be " . . . such an amount as would ordinarily be paid for comparable services by comparable institutions." 42 CFR 413.102(b)(2)(i). The refusal to reopen the 1989 cost report to correct this error is a clear *abuse of discretion*. The owners' compensation being paid to YHVNS is *not in accordance with law*. The regulation cited above legally requires payment to owners to be comparable to payment made for comparable services by comparable institutions. Comparing a single home health agency's Administrator's salary to that of a chain operation Administrator's salary is not in accordance with law.

Id. (emphasis in original).

Both courts concluded there was no basis for jurisdiction to hear the matter. Since the violation of the Secretary's own regulation was a collateral challenge and would not have addressed the merits of the underlying claim (i.e., the precise amount of allowable owners' compensation), both courts erred in their refusal to grant jurisdiction to hear that collateral challenge. Petitioner believes this is an important point that should be addressed by the Court in this case.

Also of great importance in this matter is petitioner's contention that the lower courts misconstrued the concepts set out in *Heckler v. Ringer*, 466 U.S. 602 where this Court recognized that judicial review of a claim under the Medicare statute is available only after the Secretary of Health and Human Services renders a 'final decision.' "Pursuant to her rulemaking authority the Secretary has

provided that a 'final decision' is rendered on a Medicare claim only after the claimant has pressed the claim through all designated levels of administrative review." *Id.* at 602. Plaintiffs in that case were required to exhaust their administrative remedies before pursuing an action in federal court. In the present case, petitioner attempted to follow the administrative appeal process by requesting review of the denial of the reopening. If the Secretary's reading of 42 C.F.R. § 405.1885(c) is accepted as reasonable, there is no administrative process available to exhaust when there is a denial of a reopening request. That was not the situation in *Heckler v. Ringer*:

> Although respondents would clearly prefer an immediate appeal to the District Court rather than the often lengthy administrative review process, exhaustion of administrative remedies is in no sense futile for these respondents, and they, therefore, must adhere to the administrative procedure which Congress has established for adjudicating their Medicare claims.

Id. at 619.

The Court notes that in *Weinberger v. Salfi*, the purpose of the exhaustion requirement is to prevent "premature interference with agency processes" and to give the agency a chance "to compile a record which is adequate for judicial review." *Heckler v. Ringer*, 466 U.S. at 619 n. 12 (*citing Weinberger v. Salfi*, 422 U.S. 749, 765 (1975)). These statements by the Court make it obvious that the concept of exhaustion is meant to apply to those situations in which there is an administrative review process to exhaust.

In *Michigan Academy*, 476 U.S. 667, this Court severely restricted the decision of *Heckler v. Ringer* when it upheld jurisdiction under 28 U.S.C. § 1331 to challenge the validity of a regulation authorizing payment. Therefore, to the extent that claims involve matters outside the articulated statutory review process, jurisdiction should be available under § 1331. *Medical Fund-Philadelphia Geriatric Center v. Heckler*, 804 F.2d 33, 38-39 (3rd Cir. 1986). There is a strong presumption that Congress intends judicial review of administrative action. *Abbott Laboratories v. Gardner*, 387 U.S. 136, 140 (1967). That presumption is even stronger for Medicare claims that lack an administrative forum "for it is implausible to think that Congress provided no forum to adjudicate statutory and constitutional challenges to the Secretary's policies although it provided review by Medicare carriers of claims over amounts Congress characterized as 'trivial.'" *Michigan Academy*, 476 U.S. at 677.

In the present case, the Secretary reads her regulation to preclude administrative review and also relies upon § 405(h) to preclude judicial review under federal question jurisdiction. This would allow a host of final determinations to remain completely insulated from judicial review, an extreme contradiction to the well-established presumption of judicial review of agency action. Therefore, § 405(h) should not be a bar to federal question jurisdiction for collateral claims.

IV. Is there jurisdiction for review of a refusal to reopen a Medicare provider's cost report under Mandamus Jurisdiction, 42 U.S.C. § 1361?

Petitioner believes the Medicare statute provides an administrative review process, but if the Court does not accept this view, then the alternative of federal question jurisdiction is offered as an appropriate jurisdictional grant for judicial review of final agency action. If this Court finds federal question jurisdiction is precluded by § 405(h) of the Medicare statute, then the petitioner would rely upon 28 U.S.C. § 1361 for jurisdiction in this matter. This Court has not yet ruled upon the question of whether the third sentence of § 405(h) is a bar to mandamus jurisdiction in Social Security cases:

> Assuming without deciding that the third sentence of § 405(h) does not foreclose mandamus jurisdiction in all Social Security cases, . . . the District Court did not err in dismissing respondents' complaint here because it is clear that no writ of mandamus could properly issue in this case. The common law writ of mandamus, as codified in 28 U.S.C. § 1361, is intended to provide a remedy for a plaintiff only if he has exhausted all other avenues of relief and only if the defendant owes him a clear nondiscretionary duty. See *Kerr v. United States District Court*, 426 U.S. 394, 402-403 (1976) (discussing 28 U.S.C. § 1651); *United States ex rel. Girard Trust Co. v. Helvering*, 301 U.S. 540, 543-544 (1937).

Heckler v. Ringer, 466 U.S. at 616-617.

Many Courts of Appeals that have considered the question have ruled that mandamus remains available under the Social Security Act. *Lopez v. Heckler*, 725 F.2d

1489 at 1507-8 (9th Cir.), vacated on other grounds, 469 U.S. 1082 (1984); *Ganem v. Heckler*, 746 F.2d 844, 850 (DC Cir. 1984); *Belles v. Schweiker*, 720 F.2d 509, 512-513 (8th Cir. 1983); *Kuehnor v. Schweiker*, 717 F.2d 813, 819 (3rd Cir. 1983), vacated on other grounds, 469 U.S. 977 (1984); *Ellis v. Blum*, 643 F.2d 68, 78 (2nd Cir. 1981). These cases find mandamus jurisdiction appropriate for procedural challenges where the court will not need to address substantive rights. In the present case, the petitioner challenged the intermediary's failure to follow regulations regarding the appropriate procedure to be used to determine the reasonableness of owners' compensation. 42 C.F.R. § 413.102(b)(2)(i).

There are two questions that must be answered regarding mandamus jurisdiction. First, if the plaintiff has exhausted all other avenues of relief, and second, if there is a nondiscretionary duty involved. The Sixth Circuit spoke to the question of exhaustion in its decision on the present case when it found that the district court's holding with respect to exhaustion was incorrect. *Your Home Visiting Nurse Services*, 132 F.3d 1135; Pet. App. 13. The Sixth Circuit recognized that petitioner had exhausted all available remedies with respect to its claim that the intermediary, improperly denied its request to reopen. Unfortunately for petitioner, the court went on to hold that the duty to reopen was discretionary in nature and therefore would not have triggered mandamus jurisdiction. *Id.; see also* Pet. App. 15. Petitioner disagrees with two aspects of the ruling regarding mandamus.

Petitioner asserts that the Secretary owed it two nondiscretionary duties and therefore mandamus should provide a basis for jurisdiction to permit judicial

enforcement of those duties. First and foremost, is the duty to determine reasonable cost in accordance with regulations governing that cost, a mandatory duty which was ignored by the intermediary. United State Code Title 42, Section 1395x(v)(1)(A) (emphasis added) states in pertinent part "[t]he reasonable cost of any services shall be the costs actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and ***shall be determined in accordance with regulations*** establishing the method or methods to be used." The Secretary's agent, the intermediary, violated the Secretary's own regulations because it did not pay the owners of petitioner's home health agency in accordance with regulation 42 C.F.R. § 413.102(b)(2)(i) which requires that owners compensation be "such an amount as would ordinarily be paid for comparable services by comparable institutions." The agency must abide by its own regulations. *United States v. Nixon*, 418 U.S. 683, 694-696 (1974); *Service v. Dulles*, 354 U.S. 363, 388 (1957); *Morton v. Ruiz*, 415 U.S. 199, 235 (1974). Because the Secretary is ultimately responsible for the actions of its agent, the intermediary, the Secretary is therefore responsible for the intermediary's failure to perform this nondiscretionary duty. Once the failure to pay the petitioner's owners in accordance with the applicable regulation was discovered, the request to reopen the cost reports was made, the intermediary refused the request, appeal to the Provider Reimbursement Review Board was sought. The refusal of the Board to accept jurisdiction led petitioner to resort to the judicial process where review was requested under alternative theories, one of which was mandamus. The Sixth Circuit found the decision

concerning the refusal to reopen to be discretionary but failed to address the underlying nondiscretionary duty that is the heart of the matter. If the refusal to reopen is considered discretionary, then the Secretary can violate her regulations at any time, fail to perform nondiscretionary duties, and then allow her intermediaries to exercise their discretion NOT to reopen with impunity. This creates a situation where the Secretary's agents, the insurance companies hired as fiscal intermediaries, can refuse to perform nondiscretionary functions, can violate federal regulations and yet, their refusal to abide by law will be totally insulated from corrective action. No matter what the nature of the duty is, or how blatant the refusal to perform the duty might be, it would be unreviewable under the Secretary's reading of the reopening procedure as a discretionary function.

Secondly, petitioner asserts that the Secretary is also incorrect in her interpretation of the statute as permitting her to characterize the reopening process as a discretionary function. The Secretary's reopening regulation contains both discretionary and mandatory language depending upon the circumstances. *See* 42 C.F.R. § 405.1885(a) (which states that a determination ***may*** be reopened by the intermediary or panel of hearing officers, the Board, the Secretary, or on motion of the provider, compared with paragraph (b) which states that a determination ***shall*** be reopened if HCFA notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations or general instructions issued by HCFA); *See also* 42 C.F.R. § 405.1885(d) (which states that a decision ***shall*** be reopened and revised at any time if it is established that

such determination or decision was procured by fraud or similar fault of any party to the determination or decision. As shown by these excerpts, the provider is limited in its right to receive a reopening). By use of the word 'may' (the discretionary language in 42 C.F.R. § 405.1885(a) which applies to the provider's motion for reopening) a discretionary situation is created in the Secretary's regulation. This discretionary situation was not created by the statute.

The statute regarding the duty to make regulations which allow for the corrective retroactive adjustments was drafted with mandatory terms. *See* 42 U.S.C. § 1395x(v)(1)(A) (emphasis added) (where compulsory language is used: "Such regulations ***shall*** . . . (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."). Petitioner argues that the duty to make corrective adjustments is not discretionary in the Medicare statute and therefore the reopening regulation, insofar as it purports to allow the Secretary's agents discretion for making such corrective adjustments, is not a permissible interpretation of the plain language in the Medicare statute. Since the corrective adjustment to bring the petitioner's owners' compensation in line with its competitors is a mandatory duty in accordance with the regulation at 42 C.F.R. § 413.102(b)(2)(i) and the Medicare statute noted above requiring regulations for the corrective adjustments is also mandatory in nature, the U.S. District Court and the Sixth Circuit Court of Appeals erred in failing to allow petitioner's case to proceed with

judicial review. District courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff. 28 U.S.C. § 1361. If a provider has new and material evidence or the prior determination is found to be inconsistent with law regulations or rulings, then there is a valid basis for reopening and the court has federal question and mandamus jurisdiction to review the refusal to reopen. *Memorial Hospital v. Sullivan*, 779 F.Supp. 1410, 1412-13 (D.D.C. 1991).

Therefore, if this Court accepts petitioner's view that the duty to reopen to make corrective adjustments is not discretionary, then the judiciary would be an appropriate forum for review of a refusal to reopen. If the Court accepts the Secretary's view that reopening is a discretionary determination, the petitioner would still rely upon mandamus as available to a provider, such as petitioner, where it can be shown that the intermediary failed to perform a mandatory duty. In this case, the violation of 42 C.F.R. § 413.102 is, in and of itself, the failure to perform a nondiscretionary duty. As a result, mandamus was an appropriate basis for jurisdiction to address the breach of a nondiscretionary duty.

V. Is there jurisdiction for review of a refusal to reopen a Medicare provider's cost report under the Administrative Procedure Act 5 U.S.C. § 706?

Under the Administrative Procedure Act (APA) the Secretary's decisions regarding provider's claims for Medicare reimbursement shall be set aside if the decision

is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence or contrary to law. 5 U.S.C. § 706(2)(A); *Hennepin County Medical Center v. Shalala*, 81 F.3d 743, 748 (8th Cir. 1996). In *State of Oregon* the Ninth Circuit Court of Appeals aptly noted that the Secretary's promulgation of section 1885(c) fails to make a distinction between the discretion to decide an issue and the review of an administrative body's exercise of its discretion:

> Thus, even though the Secretary has disqualified the Board by virtue of section 1885(c) from deciding whether or not the fiscal intermediary should reopen, the Board has not been disqualified from deciding whether the fiscal intermediary abused its discretion by refusing to reopen the determination. See 5 *Davis, Administrative Law Treatise*, (2d ed. 1984) § 28:10, at 311. See also *Dunlop v. Bachowski*, 421 U.S. 560, 571-73 (1975) (allowed review for abuse of discretion, even though courts could not decide the issue in question).

State of Oregon, 854 F.2d at 350.

The question of whether there was an abuse of discretion should be addressed by the Board when a final determination regarding refusal to reopen is appealed to that forum. If the refusal to reopen was arbitrary and capricious, it should be reversed. This Court has recognized the weight to be given to the agency's views will depend upon the facts of individual cases. *Good Samaritan Hospital, et al. v. Shalala*, 508 U.S. 402, 417 (1993). Where the statute entrusts the Secretary with the responsibility for implementing a provision by regulation, the court's review is limited to determining whether the regulations

exceed the Secretary's authority and whether they are arbitrary and capricious. *Heckler v. Campbell*, 461 U.S. 458, 466 (1983). In *Good Samaritan Hospital*, the Secretary's restrictive reading of the clause of the statute at issue was considered plausible and the Court felt that it closely fit the design of the statute as a whole and did not exceed her statutory authority. *Id.* In the present case, it is difficult to imagine how the Secretary could support her reading of the statute as fitting the design of the Administrative Procedure Act (APA) which allows for review of final determinations while the Secretary would prohibit such review.

It is worthwhile to note that the Board has found abuse of discretion in a refusal to reopen as recently as June 2, 1998. *See Mary Imogene Bassett Hospital v. Blue Cross and Blue Shield Association/Empire Blue Cross and Blue Shield*, PRRB decision 98-D58, http://www.hcfa.gov/regs/98d58.htm. In *Mary Imogene Bassett*, the Board found the intermediary's refusal to reopen was an abuse of discretion because the intermediary had employed an unapproved method to calculate Medicare reimbursement which was not in accordance with existing laws and regulations and which constituted a clear and obvious error. *Id.*

If this Court does not establish a provider's right to obtain review of a refusal to reopen, intermediaries may abuse their discretion and remain unchallenged. The magnitude of the loss of reimbursement which can result from a refusal to reopen may be substantial as it was in the case of *Ashland Regional Medical Center v. Shalala*, 1998 WL 156972 (E.D.Pa. 1998). The court in *Ashland* recognized the intermediary's refusal to reopen the cost

reports was "harsh" and would result in a loss to the hospital of over five million dollars. Unfortunately, the court held the intermediary's refusal to reopen was entirely within its discretion and found the Board's decision that it lacked jurisdiction was supported by substantial evidence. *Id.* at *6. In reaching this conclusion, the court made some interesting observations. The case concerned a hospital that had failed to file its cost report correctly. Because the hospital had less than 100 beds available, it would have qualified for an additional five million dollars, if it had properly reported this information to the intermediary. *Id.* at *3. The hospital requested that its intermediary reopen the cost reports at issue. The intermediary refused to reopen and the hospital appealed the decision to the Board. The Board dismissed the hearing request citing lack of jurisdiction. Appeal to the U.S. District Court was made. When the U.S. District Court for the Eastern District of Pennsylvania reviewed the case, the court focused upon the fact that the hospital had made the initial mistake:

> Indeed, there are often times in life that we are only given one bite at the apple and are forced to live with our mistakes. While this may sometimes seem unfair, life is not always fair. Thus, we refuse to hold that the agency's interpretation is unreasonable simply because it is strict and unforgiving. While requiring Ashland to live with its mistakes is indeed harsh (in this case a simple reporting error will cost the hospital over five million dollars), we cannot say that it is unjust.

Id. at *7.

Compare the Secretary's refusal to reopen to correct this mistake which would have increased the provider's reimbursement by five million dollars to the Secretary's willingness to reopen and reaudit the base year cost reports in *Regions Hospital* in order to reduce the allowable amount of reimbursement by five million dollars. *Regions Hospital,* 118 S.Ct. at 909. If the court's reasoning in *Ashland* were applied in *Regions Hospital,* then the intermediary's mistake in the original NPR would have gone uncorrected. The intermediary would have been limited to one bite of the apple. This is another example of the de facto double standard referenced earlier in this brief. The Secretary is simply not being fair. Petitioner does not believe Congress intended that Medicare providers to be treated unfairly in this harsh and inequitable fashion.

The court in *Ashland* placed great emphasis upon the fact that the mistake was made by the provider instead of focusing more precisely upon the review of the Secretary's reopening regulation. The court's discussion effectively accepted the intermediary's refusal to reopen the cost report as reasonable because the provider's mistake caused the situation in the first place. In doing so, the court virtually makes the decision about the reasonableness of the intermediary's refusal to reopen the cost report while refusing to accept jurisdiction to decide that issue. *Ashland Regional Medical Center,* 1998 WL 156972 *6. In other words, the court looked at the facts and essentially found the refusal to reopen justifiable as reasonable where the provider made the mistake and later sought correction of its own error. Further discussion by the court about situations in which the refusal to reopen

might be an abuse of discretion leads petitioner to believe that court might have ruled differently had petitioner's case been before it. The following excerpt is revealing on this point:

> Plaintiff also points out that Defendant's interpretation conflicts with the regulatory provision mandating reopenings based on fraud . . . However the case before this court does not involve fraud; it involves Plaintiff's own mistake. Thus while Plaintiff makes a strong argument that the Board's refusal to assert jurisdiction over an intermediary's refusal to reopen a case when that intermediary is involved in fraud may be unreasonable, that is not the case before the court today. We will therefore refrain from deciding the hypothetical case proposed by the Plaintiff until such a case is actually before this court.

Id. at *7.

Petitioner must emphasize that it did not make a mistake on the cost reports at issue in the present case. To the contrary, it was the wrongful conduct of the intermediary which was not discovered by petitioner until long after the initial Notice of Program Reimbursement letters had been issued which led to petitioner's request to reopen. If the intermediary had used the appropriate salary survey for home health agency administrators for chain operations which were in the same geographical area as the petitioner's home health agencies (as required by 42 C.F.R. § 413.102(b)(2)(i)) no audit adjustment to decrease the petitioner's owners' compensation would have been made in the first place. It was the error of the intermediary which caused the problem. The error was

brought to the attention of the intermediary when the request for reopening was made and yet, the intermediary refused to correct its own mistake. No justification has been offered for the refusal to correct this error. "When action is taken by the Secretary it must be such as to enable a reviewing court to decide with some measure of confidence whether or not the discretion, which still remains in the Secretary, has been exercised in a manner that is neither arbitrary or capricious . . . It is necessary for [him] to delineate and make explicit the basis upon which discretionary action is taken." *Dunlop v. Bachowski*, 421 U.S. 560, 573 (*quoting DeVito v. Shultz*, 300 F.Supp. 381, 383 (D.D.C. 1969)).

The petitioner requested reopening on the basis of new evidence, information that was discovered revealed that its owners were being paid less than other owners within the same geographical area. (Joint App. ___) The intermediary's refusal to reopen did not address the fact that petitioners owners compensation had not been considered in line with comparable agencies within the same geographical area. Nor did the intermediary's refusal to reopen give substantive explanations to support the decision. Instead, three conclusions were stated: (1) The manner in which the home office cost statement was filed was not inconsistent with the law, regulations and rulings or general instructions. (2) A clear and obvious error was not made when these cost reports were filed. (3) And, new and material evidence has not been presented to establish the compensation claimed was inappropriate. Pet. App. 36-37. As to the first conclusion, the intermediary is correct in stating that a reasonable amount of owners compensation was *claimed* on the home office cost

report. The problem is, the amount claimed was not allowed. As to the second conclusion, though it is true that a clear and obvious error was not made when these cost reports were *filed*, the intermediary made a clear and obvious error when the owners' compensation was reduced based upon comparisons to individual home health agencies instead of chain operations. Finally, the third conclusion states that new and material evidence was not presented to establish that the compensation claimed was inappropriate. The petitioner offered new and material evidence that the *reduction to compensation* was inappropriate.

Rather than address the problem presented, the intermediary ignored the basis for the request for reopening. This conduct was in total disregard of the allegations raised regarding the violation of a federal regulation which requires that owners' compensation be "such an amount as would ordinarily be paid for comparable services by comparable institutions." This is a case where the intermediary perpetuated its own mistake.

In *Ashland*, the court recognized that the Board's refusal to assert jurisdiction over an intermediary's refusal to reopen might be unreasonable in circumstances where an intermediary is involved in fraud. (The regulation contains the phrase 'fraud or similar fault'. 42 C.F.R. § 405.1885(d). Unfortunately, the Board may not be able to exercise jurisdiction even if fraud or similar faults were alleged. The Board is required to "make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary." 42 U.S.C. § 1395oo(e). Since the Board is required to act consistent

with the regulations, which are promulgated and interpreted by the Secretary and she reads 42 C.F.R. § 405.1885(c) to mean there is no review of a refusal to reopen (except for providers located in the Ninth Circuit), it remains uncertain whether the Board could accept jurisdiction of a case even if the most blatant act of fraud or similar fault were shown to exist. It is this tremendous potential for extreme abuse of discretion which cannot be corrected through the review process that makes the Secretary's position so incredibly unreasonable. There are definitely times when the Secretary's actions are considered arbitrary and capricious, an abuse of discretion and not in accordance with law. *See Loma Linda Community Hospital v. Shalala*, 907 F.Supp. 1399 (C.D.Cal. 1995). The problem with the Secretary's reading of 42 C.F.R. § 405.1885(c) is that it precludes review of every decision which refuses to reopen a cost report and therefore insulates from review even the most abhorrent abuse of discretion. This particular danger was addressed by this Court. *See Interstate Commerce Commission v. Brotherhood of Locomotive Engineers*, 482 U.S. 270 (1987). "If review of a denial to reopen for new evidence or change in circumstance is unavailable, the petitioner will have been deprived of all opportunity for judicial consideration – even on a 'clearest abuse of discretion' basis – of facts which, through no fault of his own, the original proceeding did not contain." *Id.* at 270. As evidenced by the three sentences which make up the refusal to reopen in this case, there is a need for a well reasoned decision when there is a refusal to reopen a final determination. Once such a decision is rendered, there must be a forum with the authority to review that decision and to set it aside if

the decision is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence or contrary to law. 5 U.S.C. § 706(2)(A). Therefore, jurisdiction under the APA for review of the intermediary's refusal to reopen should be available.

CONCLUSION

The Secretary's reading of the Medicare statute as evidenced by her interpretation of 42 C.F.R. § 405.1885(c) is not a permissible construction of the statute because it is in conflict with the intent of Congress and with the plain meaning of 42 U.S.C. § 1395oo, which allows review of a final determination. Therefore, petitioner requests a **ruling** from this Court declaring 42 U.S.C. § 1395oo is appropriate authority for the review of a final determination, including a final determination which is a refusal to reopen, and an **Order** remanding the case back to the Provider Reimbursement Review Board for a determination as to the appropriateness of the intermediary's refusal to reopen the cost reports at issue in this matter.

If the Court is not convinced that 42 U.S.C. § 1395oo provides an avenue for administrative appeal of refusals to reopen, then reliance upon 28 U.S.C. § 1331 must again be proposed as an alternative for jurisdiction. Even if the petitioner is successful at this juncture and wins the case based upon its reading of 42 U.S.C. § 1395oo, the question remains as to the Sixth Circuit decision that petitioner's claims were not entitled to review at the U.S. District Court level under federal question jurisdiction because the Medicare statute, 42 U.S.C. § 405(h), precludes federal

question jurisdiction as a basis for review. Therefore, if this Court accepts the Secretary's position that 42 U.S.C. § 1395oo does not provide for administrative review of a refusal to reopen, then petitioner seeks a **ruling** from this Court stating that resort to 28 U.S.C. § 1331 is appropriate for judicial review of a refusal to reopen and an **Order** remanding the case back to U.S. District Court for the Eastern District of Tennessee for review of the intermediary's refusal to reopen the cost reports at issue in this matter. In addition thereto, if this Court finds that 42 U.S.C. § 1395oo does provide for administrative review of a refusal to reopen, the petitioner nevertheless seeks a **ruling** from this Court which recognizes that 28 U.S.C. § 1331 remains available for challenges to the extent that claims involve matters outside the articulated statutory review process and validates the continuing force of the decision stated in *Michigan Academy*, 476 U.S. 667.

If this Court finds federal question jurisdiction is precluded by 42 U.S.C. § 405(h) of the Medicare statute, then the petitioner would rely upon 28 U.S.C. § 1361 for jurisdiction in this matter. Petitioner therefore requests a **ruling** by this Court that the third sentence of § 405(h) is not a bar to mandamus jurisdiction in Social Security cases, and an **Order** remanding the case back to the U.S. District Court for the Eastern District of Tennessee for judicial review of the intermediary's refusal to reopen the cost reports at issue in this matter, which petitioner asserts is a nondiscretionary duty, and in addition thereto, or in the alternative, for judicial review of the intermediary's refusal to pay petitioner's owners' compensation in accordance with regulation 42 C.F.R.

§ 413.102, which petitioner also asserts is a nondiscretionary duty.

Finally, petitioner seeks a **ruling** from this Court which states that the Administrative Procedure Act requires that decisions regarding provider's claims for Medicare reimbursement shall be set aside if the decision is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence or contrary to law, 5 U.S.C. § 706(2)(A), which includes decisions regarding refusals to reopen and therefore, the APA is an appropriate basis for review of the intermediary's refusal to reopen, and an **Order** remanding the case back to the U.S. District Court for the Eastern District of Tennessee for judicial review of the intermediary's refusal to reopen the cost reports at issue in this matter.

Respectfully submitted,

DIANA L. GUSTIN
Counsel of Record
11 Town Square
Post Office Box 1349
Norris, Tennessee 37828
(423) 494-3000
Counsel for Petitioner

APPENDIX A

42 C.F.R. § 413.102: Compensation of Owners

(a) *Principles.* A reasonable allowance of compensation for services of owners is an allowable cost, provided the necessary services are actually performed in a necessary function.

(b) *Definitions.* (1) *Compensation.* Compensation means the total benefit received by the owner for the services he renders to the institution. It includes:

(i) Salary amounts paid for managerial, administrative, professional, and other services.

(ii) Amounts paid by the institution for the personal benefit of the proprietor.

(iii) The cost of assets and services which the proprietor receives from the institution.

(iv) Deferred compensation.

(2) *Reasonableness.* Reasonableness requires that compensation allowance:

(i) Be such an amount as would ordinarily be paid for comparable services by comparable institutions.

(ii) Depends upon the facts and circumstances of each case.

(3) *Necessary.* Necessary requires that the function:

(i) Be such that had the owner not rendered the services, the institution would have had to employ another person to perform the services.

(ii) Be pertinent to the operation and sound conduct of the institution.

(c) *Application.* (1) Owners of provider organizations often render services as managers, administrators, or in other capacities. In such cases, it is equitable that reasonable compensation for the services rendered be an allowable cost. To do otherwise would disadvantage such owners in comparison with corporate providers or providers employing persons to perform similar services.

(2) Ordinarily, compensation paid to proprietors is a distribution of profits. However, where a proprietor renders necessary services for the institution, the institution is in effect employing his services, and a reasonable compensation for these services is an allowable cost. In corporate providers, the salaries of owners who are also employees are subject to the same requirements of reasonableness. Where the services are rendered on less than a full-time basis, the allowable compensation should reflect an amount proportionate to a full-time basis. Reasonableness of compensation may be determined by reference to, or in comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means.